Arizona Medical Board

9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258-5514
Telephone: 480-551-2700 • Toll Free: 877-255-2212 • Fax: 480-551-2704
Website: www.azmdboard.org • Email: questions@azmdboard.org

NAME CHANGE FORM

License #: _____

Full Legal Previous Name: _____

Full Legal New Name: _____

Reason for name change: (please attach legal documents)

_____

_____

_____

Send or fax this form along with your $50.00 payment to: (if paying by credit card, please include the attached payment card authorization form)

Arizona Medical Board
9545 E. Doubletree Ranch Rd.
Scottsdale, Arizona 85258
Fax: (480) 551-2704

_____ _____

(Signature) (Date)

Arizona Medical Board

PAYMENT CARD AUTHORIZATION
FOR NAME CHANGE

Payment for: _____**MD** Lic #_____
Physician Name

NAME CHANGE FEE: $50

Type of Card: ☐ **Visa** ☐ **MasterCard**

Card #: ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐

Expiration Date: ☐☐-☐☐ **(MM-YY)**

Name as Shown on Payment Card: _____

Billing Address of Cardholder:
(Required**)**

Street Address:

_____

City: _____ **State:** _____ **Zip:** _____

Phone Number of Cardholder: _____
(Required**)**

Mailing Address of Cardholder: (If different from billing address):

Street Address:

_____

City: _____ **State:** _____ **Zip:** _____

Signature of Cardholder: _____ **Date:**_____

Please complete and return this form *with your name change request* if paying by credit card.

Mail to: Arizona Medical Board, PO Box 6200. Scottsdale, AZ 85261-6200